Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Nonsteroidal Anti-Inflammatory Drugs (NSAID) Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Celebrex, Mobic, and Arthrotec. In addition, PA is required for Ponstel (single-source brand-name NSAID) and any brand-name multiple-source NSAID that has an FDA "A"-rated generic equivalent as identified by the ***Approved Drug Products with Therapeutic Equivalence Evaluations*** (also called the "Orange Book"). Additional information about nonsteroidal use can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID #	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information Please complete section 1 below **or** section 2 on back, depending on the drug requested.

1. Cox-2 Inhibitor/Arthrotec request

☐ Arthrotec (misoprostol/diclofenac)
☐ Celebrex (celecoxib)
☐ Mobic (meloxicam)

Dose, frequency, and duration of requested drug

Drug NDC (if known)

Is member under 60 years of age? ☐ Yes ☐ No

Indications (Check one.)

☐ Osteoarthritis ☐ Primary dysmenorrhea ☐ Familial adenomatous polyposis (celecoxib only: FDA-approved)
☐ Rheumatoid arthritis ☐ Acute pain ☐ Other, specify _____

Is member at risk for a clinically significant gastrointestinal event, as defined by one of the following?

☐ Yes (Check one.)

○ Previous history: ☐ Major GI bleed ☐ Perforation ☐ Obstruction — Dates

○ Previous history of a peptic ulcer documented by endoscopy or radiograph — Dates

☐ Concomitant therapy with any of the following (Check one.)

○ Aspirin ○ Oral corticosteroid: dose, frequency, and duration _____ ○ Warfarin: dose, frequency, and duration _____

☐ No. Has member tried two generic NSAID products?

○ Yes. Complete boxes 3A and 3B on back (Generic NSAID product courses).

○ No. Explain why not. _____

Medication information continued

2.

Brand-name multiple-source NSAID or Ponstel request	Dose, frequency, and duration of requested drug	Drug NDC (if known)
Diagnosis pertinent to requested medication		

Has member tried two generic products?

☐ Yes. Complete boxes 3A and 3B below (Generic NSAID product courses).

☐ No. Explain why not. _____

3. Generic NSAID product courses

A. Drug name		**B.** Drug name	
Dates of generic use	Dose and frequency	Dates of generic use	Dose and frequency
Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other Details of adverse reaction, inadequate response, or other		Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other Details of adverse reaction, inadequate response, or other	

Pharmacy information

Name	Pharmacy provider no. *Optional*	Telephone ( )	Fax ( ) *Optional*
Address		City	State / Zip *Optional*

Prescriber information

Last name / First name / MI			MassHealth provider no.	DEA #
Address			City	State / Zip
E-mail address *Optional*			Telephone ( )	Fax ( )

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date

DUR program use only

Reviewer's decision ☐ Approved ☐ Pended ☐ Denied

Comments/reasons for pended or denied decision _____